

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/200  
FORM APPROVE  
OMB NO. 0938-039

10/14/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/11/2008
NAME OF PROVIDER OR SUPPLIER  EL JEN CONVALESCENT HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 5538 W DUNCAN DRIVE LAS VEGAS, NV 89130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  This Statement of Deficiencies was generated as a result of an annual Medicare Recertification survey which was conducted at your facility from July 8, 2008 through July 11, 2008. The census at the time of the survey was 128. The sample size was 38, including 3 closed records.  The following complaint was investigated:  Complaint #NV16759 - Unsubstantiated  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  The following regulatory deficiencies were identified:  F 241 483.15(a) DIGNITY SS=D  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure dignity and respect was provided for 1 of 38 sampled and 2 unsampled residents.  Findings include:  Observation	F 000			
F 241		F 241	F 241 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Because practices cited do not identify specific residents and are historic in nature we are unable to correct. b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring injections, blood glucose monitoring, and the use of clothing protectors have the potential to be affected. Corrective action includes (1) Mandatory in-		
			F 241 - continued next page		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Shere R. Ridge RN*

TITLE

DON

(X6) DATE

9/12/08

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 On 7/10/08 at 4:00 PM, an un-sampled resident received an injection in his arm while sitting in his wheelchair in the middle of the hallway outside his room.  On 7/8/08, 7/9/08 and 7/10/08 (at breakfast and lunch), clothing protectors were placed on all the residents (un-sampled) in the dining room closest to the kitchen without them being asked if they would like to have one.  On 07/10/08 in the afternoon, Resident #1 received a fingerstick for a blood sugar reading while seated in the hallway among the presence of other residents.	F 241	F 241 - continued from previous page  service regarding Privacy and Dignity for all nursing staff will be conducted on 9/16/08 for all CNA's and 9/23/08 for all Licensed Nurses (see attachment F241-1), (2) Mandatory in-service regarding Medication Pass for all licensed nurses will be conducted on 9/23/08 (see attachment F241-2), (3) Amendment to policy on Dietary Assessment (see attachment F241-3), and (4)		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to reasonably accommodate the needs for 2 of 38 sampled residents (#6, #13).  Findings include:  Resident #6  Resident #6 was a 96 year old female admitted	F 246	F 246 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility is unable to correct practice cited in the case of resident #6 as the citation is historic in nature. A small bed tray that is easy for the resident to reach was placed next to the mattress on the floor for resident #13. b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents who eat could be potentially be affected as well as all residents who are maintained on a mattress on the floor for his/her safety. A mandatory in-service will be conducted on "Accommodation of Needs" In-service will include but  F246 - continued on next page		

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F 246	<p>Continued From page 2</p> <p>on 6/13/08 with diagnoses to include Chronic Obstructive Lung Disease, Depression, Hypertension, Dementia, Organic Delusional Disorder, Dysphagia, Edema of Bilateral Extremities and Gastrointestinal Reflux Disease.</p> <p>Observation</p> <p>On 07/09/08 at the noon meal, Resident #6 was observed in the dining room being fed by a Certified Nursing Assistant (CNA). The resident was in a wheelchair with her legs raised, her eyes were closed and her arms were positioned at her sides covered with a sheet. The resident ate approximately one-third of her lunch.</p> <p>On 07/09/08 in the afternoon, Resident #6 was observed tossing a ball with the Occupational Therapist (OT). The resident was observed raising her arms above her head and using a tissue to wipe her nose during therapy.</p> <p>On 07/10/08 during breakfast, Resident #6 was observed in bed being fed by a CNA. The resident ate approximately one-third of her breakfast.</p> <p>On 07/10/08 at the noon meal, Resident #6 was able to eat by herself with supervision after she requested to be positioned closer to the dining room table. The resident was able to eat two-thirds of her meal.</p> <p>On 07/11/08, Resident #6 was observed sitting at the dining room table feeding herself with cueing from a CNA. The resident ate approximately two-thirds of her meal.</p> <p>Interview</p>	F 246	<p>F246 - continued on next page</p> <p>not be limited to: (1) Allowing residents to be as independent as possible while understanding that due to cognitive changes and physical changes a resident's level of assistance can change from meal to meal. (2) Proper meal set up. (3) Access to necessary items for use. This in-service will be for all nursing and be held on 9/16/08 for CNA's and 9/23/08 for Licensed Nurses (see F246-1).</p> <p>c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Upon admission and quarterly, residents are assessed by nursing, dietary, and therapy (as applicable). The assessments include the resident's ability to perform his/her ADL's (including eating) and the amount of assistance needed from staff. Through mandatory in-service on "Accommodation of Needs" staff will understand the importance of allowing the resident to be as independent as possible but will also recognize that any resident can change in his/her level of assistance from meal to meal or day to day. Staff will also recognize the importance that no matter the situation (if the resident can use or not) the resident needs to have access to needed items like water pitcher, glasses, tissues, meals, etc. within his/her reach.</p> <p>F246 - continued on next page</p>		

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F 246	Continued From page 3  On 07/10/08, Resident #6 was interviewed after breakfast. She indicated that she usually was fed breakfast in bed however in the afternoon she liked to eat lunch and dinner in the dining room. The resident indicated she could feed herself if she was positioned closer to the dining table. She stated, "I guess they feed me because I am too slow and make a mess."  On 07/10/08, the OT revealed Resident #6 had good range of motion in her arms and hands and that she could feed herself.  Record Review  The Activities of Daily Living Rehabilitation Potential dated 06/25/08, indicated Resident #6 was to participate in Physical Therapy / Occupational Therapy to maximize her functional potential.  The Restorative Nursing Mobility Evaluation form dated 6/13/08, indicated Resident #6 had one hundred percent range of motion in her upper body.  The physician's order dated 06/18/08, indicated Resident #6 should have one-on-one supervision / assistance for all meals.  Resident #13  Resident #13, an 87 year old female, was admitted on 2/1/08 and re-admitted on 5/26/08. The diagnoses at the most current admission were Left Intertrochanteric Hip Fracture, S/P (Status Post) Closed Reduction/Internal Fixation of Left Hip, S/P Fall, Unspecified Debility,	F 246	F246 - continued on next page  d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change: All department supervisors will be responsible for ensuring that his/her employee is educated on "Accommodations of Needs" for each resident in the facility. This will be monitored during meal observation which is conducted daily by Lead CNA's, & RCC's. Deficient practices will be identified and corrected at the time. During Grand Rounds conducted weekly, department heads will assess for any "Accommodation of Needs" changes which will be discussed at Risk Management weekly.  e) Dates when corrective action will be completed: 9/30/2008		

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F 246	Continued From page 4 Difficulty With Ambulation, Congestive Heart Failure, Coronary Artery Disease, Cardiomegaly, Right Carotid Arterial Stenosis, Personal History Transient Ischemic Attack, Old Myocardial Infarction X 3, Arthritis, Dementia, Psychosis, History of Weight Loss, and Erosive Esophagitis.  Observation  On all days of the survey, a mattress was on the floor of the room occupied by Resident #13. At various times the resident was observed resting on the mattress. An overbed table, approximately 36 inches high was positioned at the end of the mattress. A pitcher of water and cups were on the table on all days of survey. There were no fluids within the resident's reach when she was reclining on the mattress.  Interview  On 7/9/08 at 9:00 am, the Certified Nursing Assistant revealed the resident was unable to arise from her wheelchair to a standing position without the physical assist of one hand to the resident's back.  On 7/11/08 at 10:40 am, the Director of Nurses revealed Resident #13 was not capable of arising from the mattress on the floor of her room.	F 246	F 246 - see previous page		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 281	F 281 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were affected.  F 281 - continued next page		

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F 281	<p>Continued From page 5</p> <p>review, the facility failed to ensure professional standards of quality were met for 1 of 38 sampled residents and 1 unsampled resident.</p> <p>Findings include:</p> <p>Observation</p> <p>On 7/8/08 and 7/9/08, two different medication nurses failed to perform hand hygiene (either by washing them with soap and water or using an alcohol based hand sanitizer) in between administration of medications to residents in their rooms and in the dining room.</p> <p>Document Review</p> <p>Guidelines for Hand Hygiene in Health-Care Settings Referenced from The Center for Disease Control-Healthcare Infection Control Practices Advisory Committee October 25, 2002.</p> <p>Rationale for hand hygiene:</p> <ul style="list-style-type: none"> <li>-Potential risks of transmission of microorganisms</li> <li>-Potential risk of health-care worker colonization or infection caused by organisms acquired from the patient</li> <li>-Morbidity, mortality and costs associated with health-care associated infections</li> </ul> <p>Indications for hand-hygiene</p> <ul style="list-style-type: none"> <li>-Contact with a patient's intact skin (examples. taking pulse, blood pressure, performing physical examinations, lifting the patient in bed).</li> <li>-Contact with environmental surfaces in the immediate vicinity of patient's</li> </ul>	F 281	<p>F 281 - continued from previous page</p> <p>b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Any resident who resides here has the potential to be affected. The following corrective actions will be taken: 1. Mandatory in-service on Medication Pass Procedures including but not limited to infection control during the med pass.</p> <p>c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; In-service on Medication Pass Procedure will be conducted on 9/23/08 for all licensed nurses (see F281-1). Measures put into place will include continuation of monthly med pass audits by the Pharmacy Nurse Consultant, and random rounds by RCC's and DON during medication pass times.</p> <p>d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change; Corrective action will be monitored through random medication pass audits conducted by the RCC's, DON, and Nurse Consultant from pharmacy. Nurses found not to be practicing hand hygiene during the med pass will be corrected immediately with weekly</p> <p>F 281 - continued next page</p>		

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F 281	Continued From page 6 -After glove removal  Techniques for hand hygiene  -Amount of hand-hygiene solution -Duration of hand-hygiene procedures -Selection of hand-hygiene agents -Alcohol-based hand rubs are recommended for routine decontamination of hands for reducing the number of bacteria on the hands of personnel. Antiseptic soaps and detergents are the next most effective, and non-antimicrobial soaps are the least effective. -Soap and water are recommended for visibly soiled hands. -Alcohol-based hand rubs are recommended for routine decontamination of hands for all clinical indications (except when hands are visibly soiled) as one of the options for surgical hygiene.  Interview  On 7/10/08, the Director of Nurses (DON) indicated she would expect the nurse to perform hand hygiene in between residents while passing medications anywhere in the facility.	F 281	F 281 - continued from previous page reports and offenders discussed at weekly Risk Management meetings with disciplinary action implemented as deemed necessary. c) Dates when corrective action will be completed: 9/30/2008		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:	F 323	F 323 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No specific residents have been affected. b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents with a diagnosis of  F 323 - continued next page		

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F 323	<p>Continued From page 7</p> <p>Based on observation, interview, and record review, the facility failed to ensure that 9 of 38 residents received adequate supervision and assistance devices to prevent accidents for residents with a diagnosis of seizure disorder (#7, #26, #27, #28, #29, #32, #33, #34 and #37).</p> <p>Findings include:</p> <p>Observation</p> <p>On all days of the survey, Residents #7, #26, #27, #28, #29, #32, #33, #34 and #37 were observed without padded side rails while in bed or a landing strip on the floor.</p> <p>Interview</p> <p>On 07/08/08 in the afternoon, the Director of Nurses indicated the facility had no written policy for seizure precautions however, the staff had an inservice on orientation. She indicated residents either had padded side rails (if they used side rails) or a landing strip on the floor.</p> <p>On 07/11/08, Employees #14 and #16 indicated seizure precautions included padded side rails and a landing strip on the floor.</p> <p>On 07/11/08 in the afternoon, Employee #15 indicated he would call a nurse if a resident was having a seizure. He indicated he was not sure what else to do.</p> <p>Record Review</p> <p>The current Medication Administration Records for Residents #7, #26, #27, #28, #29, #32, #33, #34 and #37, indicated the residents were on</p>	F 323	<p>F 323 - continued from previous page</p> <p>seizure disorder have the potential to be affected. New policy written regarding residents with seizure disorder (see attachment F323 - 1 for policy). All nursing staff will attend a mandatory in-service regarding new policy on residents with seizure disorder CNA's will be in-serviced 9/16/08 and Licensed Nurses on 9/23/08 (see attachment F323 - 2 for in-service material).</p> <p>c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Policy has been written regarding residents with seizure disorders. As with any other disease process interventions and precautions are resident specific. We will continue to discuss with resident's attending physician to identify what interventions if any, he/she desires for his individual resident. Appropriate orders will be written and individual resident specific care plans done accordingly.</p> <p>d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change: Resident's condition is monitored every shift and as needed in accordance with policy. Attending physician will be notified of any changes in resident's status.</p> <p>e) Dates when corrective action will be completed: 9/30/2008</p>		

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F 323	Continued From page 8 anti-seizure medication.  The current physician's orders for Residents #7, #26, #27, #28, #29, #32, #33, #34 and #37, indicated the residents had side rails up while in bed for positioning.	F 323	F 323 - see previous page		
F 328 SS=D	<b>483.25(k) SPECIAL NEEDS</b>  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 of 38 residents received an enteral feeding as ordered (#15).  Findings include:  Resident #15  Resident #15, an 87 year old female, was admitted on 2/21/08 with diagnoses including Organic Delusional Disorder, Progressive Dementia, Unspecified Debility, Cognitive Dysfunction, Dysphagia Due to Cerebrovascular Disease, Dysphagia of Oropharyngeal Phase, Attention to Gastrostomy, Hypokalemia, and Poor	F 328	<b>F 328</b> a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #15's MAR was corrected at the time of the survey. A medication error report was completed and the family and physician were notified. b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All resident's who require bolus tube feedings have the potential to be affected. A mandatory in-service will be conducted on re-capping of physicians orders for all licensed nurses. c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Mandatory in-service will be for all licensed nurses will be conducted on 9/23/08 regarding accuracy of re-capping physician's orders (see F 328-1) d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to  F 328 - continued next page		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/20/2008  
FORM APPROVE  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  <b>295008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/11/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>EL JEN CONVALESCENT HOSP SNF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>5538 W DUNCAN DRIVE LAS VEGAS, NV 89130</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 328	<p>Continued From page 9</p> <p>Oral Intake.</p> <p>Observation</p> <p>On 7/11/08 after the breakfast meal, Resident #15 was observed in bed in her room. The Licensed Practical Nurse (LPN) requested the Certified Nursing Assistant (CNA) to place the resident in a geri-chair in preparation for a bolus formula feeding.</p> <p>The resident was seated in a geri-chair at approximately an 80 degree angle. The LPN administered a bolus feeding of 200 milliliters (ml.) of water and 200 ml. of Fibersource formula.</p> <p>Interview</p> <p>On 7/11/08 after the breakfast meal, the LPN revealed the oral intake for the resident at breakfast was 25%. The LPN indicated that a bolus feeding of Fibersource was given anytime the resident ate less than 50% at a meal.</p> <p>The LPN poured 200 ml of Fibersource formula into a graduated cylinder and indicated that the order was for 200 ml and she would discard the remainder of the formula in the can. The can contained 250 ml. of formula per its label.</p> <p>Record Review</p> <p>The orders dated 5/07/08, indicated "Fibersource 250 ml bolus via G (gastrostomy) tube if resident eats less than 50% of a meal." Another order stated "Flush G tube with 200 cc (cubic centimeters) of water after every four hours."</p> <p>A dietary order dated 4/23/08, was for an oral diet</p>	F 328	<p>F 328 - continued from previous page</p> <p>monitor the continued effectiveness of the systemic change; At end of month change over, night shift will compare the old MAR's with the new ones to ensure that all orders were recapped correctly. In the event that an error is noted, he/she will correct the error and notify the respective RCC in writing of the error that was made so responsible nurse will be made aware and disciplinary action taken as deemed necessary (see Policy regarding Re-capping of Physician orders F 328-2)</p> <p>e) Dates when corrective action will be completed: 9/30/2008</p>		

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F 328	Continued From page 10 of pureed RCS (Reduced Concentrated Sweets) and on 4/28/08, was for honey thick liquids (in 2.5 cc amounts with all meals for breakfast, lunch and dinner).  The Medication Administration Record (MAR) for July 2008, indicated the following in the column labeled formula strength, calories, flow rate: "Give Fibersource 200 ml bolus via G -tube if resident eat <50% (per cent) each meal". The MAR for 7/1 through breakfast on 7/11/08 indicated that the resident received the bolus feeding for 30 of the 31 meals documented. The "Food & Fluid Intake Worksheet" indicated that on July 1 the resident ate 100% at the mid-day meal. The MAR indicated that on July 1st at the noon meal, per order, the resident did not receive a feeding.  For the 30 bolus feedings administered at 200 ml for July 2008, the resident received 1500 ml formula, 1800 kilocalories and 64.5 grams of protein less than ordered.  The most current laboratory report, dated 4/18/08, indicated the total protein was low at 4.8 grams/deciliter (g/dl). The reference range was indicated as 6.0 -8.0 g/dl.  The Care Plan indicated that the resident had a problem of "Hx (history) failure to thrive with weight loss..." The approach included "Provide Fibersource 250 ml bolus via g-tube if eats <50% (less than 50 percent) of a meal-flush g-tube with 200 cc of water Q (every) 4 hours."	F 328	F 328 - see previous page		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY  Menus must meet the nutritional needs of residents in accordance with the recommended	F 363	F 363 - See next page		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  295008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  07/11/2008
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F 363	<p>Continued From page 11</p> <p>dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that menus were followed.</p> <p>Findings include:</p> <p>Observation</p> <p>1. On 7/10/08 during the breakfast meal, French toast was served. The posted menu item of biscuits with gravy was not served. The residents eating in the Garden Dining Room received an egg in addition to the French toast. Some of the residents in the assisted dining and independent dining room received bacon with the French toast.</p> <p>2. On 7/10/08 at the noon meal, residents on puree diets received pureed ham, pureed baked beans, mashed potatoes with gravy, and applesauce.</p> <p>Document Review</p> <p>1. The menu did not indicate that eggs or bacon were to be served.</p> <p>2. The puree menu for the 7/10/08 noon meal, included pureed baked ham, ham glaze, pureed canned baked beans, pureed seasoned cabbage, and pureed chocolate chip bar.</p>	F 363	<p>F 363</p> <p>a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Because events were historical in nature we are unable to correct the specific citation.</p> <p>b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. All dietary staff will attend a mandatory in-service on 9/17/08 regarding the facility policy on Menus and changes in menus (see attachment F363 - 1). All altered diet types (mechanical soft, pureed, etc.) shall receive the exact same foods that are served on the regular diets.</p> <p>c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; On a weekly basis, the dietary manager and/or his/her designee will compare food items ordered and items received. At that time if an item required for the menus for the following week is unavailable he/she will notify the Registered Dietician of the change to ensure that the change is nutritionally equivalent, change the menu on the posted menus, document the change and the reason for it, and report any changes in weekly Risk Management meeting.</p> <p>F 363 - continued next page</p>		

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F 363	Continued From page 12 Interview  On 7/10/08 at 12:15 pm, the cook indicated there was no cornbread puree as bread left from breakfast was pureed with the pureed meat. The cook indicated that no cabbage was pureed. She indicated that pureed bread and pureed vegetables were always added to the pureed meat.  On 7/11/08 at 10:30 am, the dietary manager indicated that the cook used pureed Texas toast but no vegetables in the pureed ham at the noon meal on 7/10/08. The manager indicated that the puree diets were not served puree corn bread, pureed seasoned cabbage, and pureed chocolate chip bar. The dietary manager stated that 17 residents received puree diets. The dietary manager indicated that biscuits and gravy were not served as the gravy was not received on the food delivery.	F 363	F 363 - continued from previous page  d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change: This practice will be monitored through Risk Management (see F 363 - 2 for Risk Management minutes). e) Dates when corrective action will be completed: 9/30/2008		
F 364 SS=D	483.35(d)(1)-(2) FOOD  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food at acceptable temperatures at point of service.  Findings include:  Observation	F 364	F 364 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were affected. b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. Corrected action plan as follows: (1) Mandatory In-service with all dietary staff regarding food temperatures will be conducted on 9/17/08 (see attachment F 364 - 1 for  F 364 - continued next page		

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F 364	Continued From page 13  On 7/10/08 at 12:00 pm, three enclosed metal carts were delivered at staggered, timed intervals to the main dining room. At 12:34 pm, a puree test tray was in the main dining room. All trays had been passed to the residents in the independent and assisted dining areas of the room by that time. Four of the delivered meal trays had lids over the entree plate. At 1:04 pm, the last covered entree was uncovered and a resident was fed the puree meal.  At 1:04 pm, temperatures of the puree test tray included pureed navy beans at 98 degrees Fahrenheit (F) and pureed ham with bread at 120 degrees F. (At 11:55 am, the temperature of the foods in the steam table in the kitchen were 170 degrees F and 172 degrees F respectively.)  Interview  Nursing staff indicated that the resident who was fed the last tray (puree) was not capable of feeding herself.  F 371 483.35(i)(2) SANITARY CONDITIONS - FOOD SS=D PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food under sanitary conditions.  Findings include:	F 364	F 364 - continued from previous page  in-service material). Dietary Policy regarding Safety Precautions - Preparation and Service of Foods amended (see attachment F 364 - 2 for policy). c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; Mandatory in-service for all dietary personnel as well as amendment of current policy and procedure for Safety Precautions - Preparation and Service of Foods. d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic change; Personnel on call for staffing will continue to do  F 364 - continued on back		
F 371	483.35(i)(2) SANITARY CONDITIONS - FOOD SS=D PREP & SERVICE  The facility must store, prepare, distribute, and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve food under sanitary conditions.  Findings include:	F 371	F 371 a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were affected. b) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. The wall vent that was located at the clean end of the ware  F 371 - continued next page		

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**F 364 - continued on front page**

tests trays (see attachment F 364 - 3 for copy of test tray form). The results of the test tray will be given to the Kitchen Dietary Manager who will review. Weekly in Risk Management the Kitchen Dietary Manager will report any abnormal food temperatures obtained at the point of service as well as on the test tray reports. This will include, what was done as a result and what the Kitchen Dietary Supervisor's plan of correction is (see attachment F 364 - 4 for Risk Management Minutes).

- c) Dates when corrective action will be completed: 9/30/2008

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F 371	Continued From page 14  Observation  On 7/10/08 in the morning, the wall vent located at the clean end of the warewashing machine had an accumulation of dust in the vent.  On 7/10/08 at 11:55 am, the temperature of mashed potatoes, taken at a 2 inch depth, was 128 degrees Fahrenheit (F). The cook served the mashed potatoes from the top of the pan.  Interview  The cook indicated that the temperature of the mashed potatoes when taken from the steamer was above 140 degrees F.	F 371	F 371 - continued from previous page  washing machine was cleaned at the time of the survey. Corrected action plan as follows: (1) Mandatory In-service with all dietary staff regarding food temperatures and sanitary conditions will be conducted on 9/17/08 (see attachment F 371 - 1 for in-service material). Dietary Policy regarding Safety Precautions - Preparation and Service of Foods amended (see attachment F 371 - 2 for policy). Dietary daily cleaning checklist has been amended to add wall vent cleaning (see attachment F 371 - 3 for daily cleaning schedule). c) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: (1) Mandatory In-service with all dietary staff regarding food temperatures and sanitary conditions will be conducted (see attachment F 371 - 1 for in-service material). Dietary Policy regarding Safety Precautions - Preparation and Service of Foods amended (see attachment F 371 - 2 for policy). Dietary daily cleaning checklist has been amended to add wall vent cleaning (see attachment F 371 - 3 for daily cleaning schedule). d) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to  F 371 - continued on back		

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F 371 - continued from front page

monitor the continued effectiveness of the systemic change; Daily the Dietary Manager in the Kitchen will monitor the daily cleaning schedule. Weekly one of the Dietary Managers will conduct a mock inspection of the Kitchen (see kitchen mock survey form attachment F 371 - 4). Personnel on call for staffing will continue to do tests tray weekly (see attachment F 371 - 5). The results of the test tray will be given to the Kitchen Dietary Manager who will review. Weekly in Risk Management the Kitchen Dietary Manager will report any abnormal food temperatures obtained at the point of service as well as on the test tray reports. This will include, what was done as a result and what the Kitchen Dietary Supervisor's plan of correction is (see attachment F 371 - 6 Risk Management Minutes).

- e) Dates when corrective action will be completed: 9/30/2008

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